PIER

PARTNERS IN EMPOWERMENT AND RECOVERY

PIER ACT Program Referral: Demographic Information		
Name of person being referred:	Date of birth:	Today's date:
Address:	City, State:	Zip code:
Phone number:	Social Security Number:	

How does this person meet ACT Criteria? (Please check all that apply)	
1. Primary Mental Health Diagnosis of:	☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Bipolar Disorder (Severe and Recurrent) ☐ Major Depressive Disorder (Severe and recurrent) Other:
2. Significant Functional Impairment: (please explain)	Difficulty with tasks of adult functioning: Difficulty maintaining employment: Difficulty maintaining safe living situation:
3. High cost/treatment failure in traditional services:	☐ Two or more in-patient admission in past 24 months ☐ Greater than 4 weeks of hospitalization in the past 12 months ☐ Greater than 3 months of residential care in the past 12 months ☐ Decompensation or high risk of decompensation with traditional treatment due to treatment noncompliance, or severe life stress
4. Psychiatric Hospitalizations in past 2 years: ____ Days ____ Weeks 5. Incarcerations in past 2 years: ____ Days ____Weeks	6. Legal Status: ☐ MHB Commitment ☐ Parole/Probation ☐ Court Order ☐ Voluntary 7. Appointed Guardian? ☐ Yes ☐ No If yes Guardian name & phone:

Previous/Current Services	
Psychiatrist:	Primary Care Physician:
Physical health conditions or diagnosis:	

Current Medications & Dosage
Services utilized in past 2 years (therapists, community based services, residential care):

Nebraska Medicaid: ☑ Yes ☐ No ☐ Nebraska Total Care #: ☐ United Healthcare #: ☐ Wellcare #: Non Medicaid/Region V for this service: ☐ Yes ☐ No	If No are they eligible for Nebraska Medicaid? ☐ Yes ☐ No Current resident of Lancaster county: ☐ Yes ☐ No
Referral Source (Contact name and Agency):	Referral contact information (phone, email, mailing address):

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